IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
KARL B. KURTZ – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7000 1670 0011 3314 9047

August 18, 2006

Stacy Schoonover, Administrator
Gooding Rehabilitation & Living Center
1220 Montana Street
Gooding, ID 83330

Provider #: 135083

Dear Ms. Schoonover:

On **August 7, 2006**, a fire safety survey was conducted at Gooding Rehabilitation & Living Center by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency in your facility to be widespread deficiencies that constitute no actual harm, but have potential for more than minimal harm and are not an immediate jeopardy, as evidenced by the attached CMS Form 2567L whereby corrections are required.

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567L, listing Medicare/Medicaid deficiencies, and a similar form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance. NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Date Certain" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567L and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.**

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 31, 2006**. Failure to submit an acceptable PoC by **August 31, 2006**, may result in the imposition of civil monetary penalties by **September 20, 2006**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **September 11, 2006 (Date Certain)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **September 11, 2006**. A change in the seriousness of the deficiencies on **September 11, 2006**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **September 11, 2006** includes the following:

Denial of payment for new admissions effective **November 7, 2006**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **February 7, 2007**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact me with your written credible allegation of compliance at the following address:

Bureau of Facility Standards — DHW

3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036

If you choose and so indicate, the POC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **August 7, 2006** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR 488.331, you have the opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send a written request which states the specific deficiencies being disputed, and explains why you are disputing those deficiencies. This request must be received by **August 31, 2006**.

All required information should be as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf

If your request for informal dispute resolution is received after **August 31, 2006**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

MARK P. GRIMES
Supervisor
Facility Fire Safety and Construction

MPG/dmj

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135083	A. BUILDING 01 - ENTIRE BUILDING B. WING _____	08/07/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOODING REHAB & LIVING CTR	1220 MONTANA ST GOODING, ID 83330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The building is a single story structure of Type V(111) construction. It is fully sprinklered and has a complete fire alarm system to include smoke detection in hallways and open spaces. There is no basement and the building was completed in August of 1970. Currently it is licensed for 80 SNF/NF beds. The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on 7 August, 2006. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, adopted 11 March, 2003. In accordance with CFR 42, 483.70. The Survey was conducted by: Chris Laumann, Health Facility Surveyor	K 000	RECEIVED AUG 3 1 2006 DIV. OF MEDICAID RECEIVED AUG 3 1 2006 FACILITY STANDARDS	
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by:	K 025	K 025 To ensure safety to all the residents' fire caulk was applied to the 2 inch gap around the sprinkler head located within the East hallway adjacent to the fire doors. The Maintenance Director or designee will do a monthly audit to ensure there is no gap around any of the sprinkler heads. The Maintenance Director will report findings at the monthly QA meeting.	9/14/06

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mary Mohrmann	Administrator	8-31-06

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 025	Continued From page 1 Based on observation it was determined that the facility failed to maintain the ceilings within the corridor in a state to resist the passage of smoke. This had the potential to effect all residents and staff within that smoke compartment, of the four smoke compartments. Findings include: 1.) During a facility tour on 7 August, 2006 at 1:00 PM, it was observed that a 2 inch gap around a sprinkler head located within the East hallway adjacent to the Fire doors, compromised the required half hour resistive rating of the corridor. In accordance with NFPA 101 Life Safety Code section 8.3, smoke barriers are constructed to provide at least a one half hour fire resistance rating. Observations were witnessed and noted by survey team and facility maintenance supervisor.	K 025		

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K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure that all doors in smoke barriers sealed against the passage of smoke. This deficient practice affected all residents and staff within two of four smoke compartments. The facility had a census of 59 residents. Findings include: 1. During the facility tour on 7 August, 2006, it was observed by surveyor and maintenance staff at 1:40 PM that the smoke doors separating the South hallway from the rest of the facility did not create a smoke tight barrier due to a gap in the top of the frame measuring 2 inches in length where the frame had been broken.	K 027	K 027 To ensure safety for all the residents' and staff a new strip was placed to the South hallway doors to create a smoke tight barrier. The Maintenance Director or Designee will do a monthly audit to ensure all doors in smoke barriers are sealed against the passage of smoke. The Maintenance Director will report finding at the monthly QA meeting.	9/10/06

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K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations it was determined that the facility failed to ensure proper smoke resistive separation requirements for hazardous areas i.e. a soiled utility room, the laundry room, and a boiler room. All 59 residents were effected. Findings include: 1. Observations made at 1:15 PM on 7 August, 2006, revealed that the smoke barrier required separation had been compromised due to holes measuring approximately 2 inches in diameter protruding through the ceiling of the laundry room. 2. Further observation on 7 August, 2006 at 10:45 AM, revealed a penetration in the ceiling of the East Hallway Boiler room approximately 2 inches in diameter, which compromised the integrity of the smoke resistant barrier between the room and the rest of the facility 3. Observation of laundry room on 7 August, 2006	K 029	K 029 To ensure safety for all of the residents' Fire caulk was placed around the holes in the ceiling of the laundry room. Fire caulk was used to seal the ceiling of the East Hallway Boiler room, which compromised the integrity of the smoke resistant barrier between the room and the rest of the facility to ensure the safety of all residents'. Fire Caulk was uses to seal the piping that had been installed and where old piping had been removed to ensure the safety of all residents'. The Maintenance Director or Designee will do monthly audits to ensure proper smoke resistive separation requirements for hazardous areas i.e. a soiled utility room, the laundry room, and a boiler room. The Maintenance Director will report findings monthly at the QA meetings.	9/10/06

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K 029	Continued From page 4 at 10:40 AM, disclosed numerous penetrations ranging from finger width to 2 inches in diameter Spanning through the walls, where new piping had been installed and where old piping had been removed, compromising the integrity of the required smoke resistant barrier. All findings were observed and noted by maintenance supervisor and surveyor.	K 029		
K 143 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was	K 143	K 143 The linoleum floor surface has been removed leaving a concrete barrier floor to ensure the safety of all residents and staff. To ensure the safety of all residents' and staff the attic access will be closed with a sign stating no attic access. In the future if new storage is needed for oxygen Maintenance Director and Administrator will ensure proper storage is in place prior to initiating.	9/10/06

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K 143	Continued From page 5 determined that a liquid oxygen storage room was not equipped with a specific design requirement as noted in the Life Safety Code and NFPA Standard 99. This deficiency affected all residents and staff in the within facility with a census of 59 residents.. The findings include: 1. Observation on August 7, 2006 at 1:27 PM, disclosed that the floor of the liquid oxygen storage area was not equipped with either a concrete or ceramic tile floor. A linoleum floor surface had been installed prior to the liquid oxygen units being placed in the room and subsequently was the floor finish. Interview with staff on August 7, 2006 at 1:27 PM, disclosed that transfilling had taken place in the room. 2. Further observation on August 7, 2006 revealed that the oxygen transfilling room was also being used as an access to the Attic. There was an opening measuring approximately 2 feet by 3 feet in the ceiling, compromising the required 1 hour fire barrier.	K 143		
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observations during our facility tour it was determined that the facility failed to ensure compliance with electrical safety regulations. The	K 147		

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K 147	Continued From page 6 facility had a census of 59 residents with a complete staff, all of whom were in danger of electrocution and exposure to fire. Findings include: 1. Observation on 7 August, 2006 between the hours of 10:30 AM and 2:00 PM disclosed that 3 electrical panel doors located in the Kitchen, East hallway, and the North hallway did not secure as required by NFPA 70, 1.1.110.27, National Electrical Code to protect the unit from damage and residents from harm. 3. Observation on 7 August, 2006 at 1:40 PM, also revealed that a electrical outlet in room 5 exhibited a broken outlet cover, exposing live wires. All finding were observed and noted by survey team and maintenance supervisor.	K 147	K 147 The 3 electrical panel doors located in the kitchen, east hallway, and the north hallway that did not latch securely were replaced. The electrical outlet cover in room 5 was replaced The Maintenance Director or Designee will do weekly audits for the one month if no issues will do monthly audit to ensure that all panel doors latch securely to ensure the safety of all residents' and staff. The Maintenance Director or Designee will do a full house audit of all electrical outlets monthly to ensure the safety of all residents' and staff. The Maintenance Director will report findings at the monthly QA meeting.	9/10/06

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C 000	INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The building is a single story structure of Type V(111) construction. It is fully sprinklered and has a complete fire alarm system to include smoke detection in hallways and open spaces. There is no basement and the building was completed in August of 1970. Currently it is licensed for 80 SNF/NF beds. The following deficiencies were cited during the annual Fire Life Safety survey conducted on 7 August, 2006. The facility was surveyed under IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities. The Survey was conducted by: Chris Laumann, Health Facility Surveyor	C 000	RECEIVED AUG 31 2006 FACILITY STANDARDS	
C 230	02.106,02,b b. Existing facilities licensed prior to the effective date of these rules, regulations and minimum standards and in compliance with a previous edition of the Life Safety Code may continue to comply with the edition in force at that time. This Rule is not met as evidenced by: ;	C 230		

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C 230	Continued From page 1 Refer to Federal tags K025 as it relates to maintaining the integrity of a means of egress, K027 as it relates to smoke barriers and doors, K029 as it refers to protection of hazardous areas, K143 as it refers to liquid oxygen transfilling locations, and 147 as it relates to electrical requirements all of which can be found on form CMS - 2567.	C 230	Please Refer to K025 Please Refer to K027 Please Refer to K029 Please Refer to K143	
C 265	02.106,10,b b. Rooms housing heating appliances shall not be used for storage of combustible materials. This Rule is not met as evidenced by: Based on observation and staff interview it was determined that the facility failed to ensure that nothing was stored around gas fired heating devices. The finding include: 1.) During a tour of the facility on the morning of 7 Aug, 2006 between the hours of 10:30 AM and 2:00 PM, its was observed that the facility stored combustable materials in both the exterior and interior boiler rooms. Findings in the Exterior boiler room included a wooden pallet, a wheel chair, and garden hoses within the exterior utility room housing the gas fired heating appliances. Findings in the Interior boiler room included a stack of cardboard boxes. Observations were witnessed and noted by survey team and facility maintenance supervisor.	C 265	C 265 All combustible materials in both the exterior and interior boiler rooms were removed to ensure the safety of all the residents' and staff. The Maintenance Director or Designee will do a weekly times one month if no issues will do monthly audits to ensure that nothing is stored around gas fired heating devices. The Maintenance director will mark off the area so it alerts all staff that items may not be stored in the area marked.	9/12/06